Date: _____/_____/_____ E-mail: ___________________________________ Cell Phone: (_______) __________-___________

Patient's Name: ____ SS#: _________-_________-_____________

Address: ____ Home Phone: (______) _______-_______ DOB: _____/_____/_______

City, State: ______________________________ ZIP: ________ Gender: Female ☐ Male ☐ Marital status: ___________________

Employer: ___________________________ Work Phone: (______) ______-______ Occupation: ________________________________

Work Address, City, State: ____

Preferred Language: _________________________ Preferred Pharmacy: ____

Who Referred you here: Brochure/Family/Yellow Pages/Hospital/Doctor: ____

Race: White African American Asian Other: ____

Ethnicity: Not Hispanic/Latino Hispanic /Latino

Emergency Contact Name: ____ Phone Number: (______) ______-__________

Emergency Contact Relationship to Patient: ____

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company: ____ Phone Number: (______) _______-_____________

Name of Insured: ____ Patient Relationship to Insured: ______________________

Subscriber ID (Policy #): _______________________ Group ID: __________________ Social Security: ______/______/________

Effective Date: ____________________ Date of Birth _______/_______/_________

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Insurance Company: ____ Phone Number: (______) _______-_____________

Name of Insured: ____ Patient Relationship to Insured: ______________________

Subscriber ID (Policy #): _______________________ Group ID: __________________ Social Security: ______/______/________

Effective Date: ____________________ Date of Birth _______/_______/_________

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient Signature ____ Date: ________________________

PATIENT CONSENT FOR FINANCIAL COMMUNICATIONS

1. ____________**(Patient or Guardian Initials)**

Financial Agreement.
I acknowledge, that as a courtesy, **EPMFM** may bill my insurance company for services provided to me.
I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
I understand that there is a fee for returned checks.

2. ___________**(Patient or Guardian Initials)**

Third Party Collection. I acknowledge that **EPMFM** may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

3. ___________**(Patient or Guardian Initials)**

Assignment of Benefits. I hereby assign to **EPMFM** any insurance or other third-party benefits available for health care services provided to me. I understand **EPMFM** has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to **EPMFM,** I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

4. ______________**(Patient or Guardian Initials)**

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to **EPMFM** by the Medicare or Medicaid program.

5. ______________**(Patient or Guardian Initials)**

Consent to Telephone Calls for Financial Communications. I agree that, in order for, **EPMFM** or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that **EPMFM** or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or **EPMFM** or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. ______________**(Patient or Guardian Initials)**

A photocopy of this consent shall be considered as valid as the original.

Patient/Patient Representative Signature:

X____ **Date**______________

If you are not the Patient, please identify your Relationship to the Patient.
(Circle or mark relationship(s) from list below):

Spouse	Guarantor
Parent	Healthcare Power of Attorney
Legal Guardian	Other (please specify) ______________________________

Office Policies

Thank you for choosing **EPMFM.** We shall do our best to provide you with quality and courteous care of your Maternal Fetal Medicine needs.

Notice of Form Fee

There will be a $25.00 charge for completion of FMLA/disability (or other) forms, which is due at the time the form is brought into the office. Please allow 1 week from the time the form is brought in (and/or the time of the last office visit) for completion of the form so that the insurance clerk has all the necessary information to complete the form.

Appointment Cancellation/No Show Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, **EPMFM** reserves the right to charge a fee of $35.00 for all missed appointments which are not cancelled with a 24-hr advance notice. This fee will be billed directly to the patient/guardian and is not covered by insurance carriers. Multiple missed appointments in any 12 month period may result in separation from our practice.

Late Arrival Policy

Due to the high volume of demand for medical services, late comers (10+min) may be required to reschedule their appointment for a later time or another day. If the physicians schedule can still accommodate you, priority will be given to the patients who arrived on time and you may be worked in between them. This means you may have a considerable wait. One or two late patients cause the entire daily schedule to fall behind. We strive to see every patient as close to their appointment time as possible. Multiple late arrivals in any 12/month period may result in separation from our practice.

Medication Refill Policy

A 48 hour notice is needed for refill of medication. If appointments have been missed or cancelled or treatment is not current, medication may not be renewed. Pain medication needs to be filled from your Primary Physician or your Pain Management Physician. Medication will not be renewed when requests are called to the answering service after office hours or on weekends and holidays.

Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients. By signing below, you acknowledge that you have received this notice and understand our policies. Thank you

Signature: ____ Date: _____/______/_______

General Consent for Care and Treatment

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

I voluntarily request a physician, and/or midlevel provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other healthcare providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing, and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive, or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

____ ____________________________

Signature of Patient or Personal Representative **Date**

____ ____________________________

Printed Name of Patient or Personal Representative **Relationship to Patient**

____ ____________________________

Printed Name of Witness Employee Job Title

____ ____________________________

Signature of Witness Date

EPMFM Patient HIPAA Acknowledgment and Consent Form

Location Name			
Patient Last Name (Printed)	Patient First Name (Printed)	MI	Date of Birth (MM/DD/YYYY)

Notice of Privacy Practice/clinics

________ (**Patient/Representative initials)** I acknowledge that I have received the Notice of Privacy Practice, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practice.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Communications about My Healthcare

I agree the Provider or an agent of the Provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications

If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicer have obtained, at any text number forwarded, or transferred from that number. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care.

Note: You may opt out of these communications at any time. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details). **Note:** This location uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated locations that share an electronic health record in which you have a relationship.

EPMFM Patient HIPAA Acknowledgment and Consent Form

Location Name			
Patient Last Name (Printed)	Patient First Name (Printed)	MI	Date of Birth (MM/DD/YYYY)

Release of Information.

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior service(s) at other HCA affiliated providers may be made available to subsequent HCA-affiliated providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

Patient/Representative Signature	Relationship to Patient (self, parent, legal guardian/representative, etc)	Date

Practice:OPTIONAL ON FORM- REMOVE THIS Prescription Order Pick up Section **ONLY** if NA to your practice/clinic]

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

- ***I do want ____*** (Patient/Representative Initials) to designate the following individual to pick up a prescription order on my behalf:

NAME	Relationship to Patient

- ***I do not want ____*** (Patient/ Representative Initials) to designate anyone to pick-up my prescription order.

1700 N. Oregon, Suite 790
El Paso, Texas 79902

Name: ____ **DOB**: _________________________

Please Circle One: White African American Asian Other: ______________________

Please Circle One: Not Hispanic/ Latino Hispanic/ Latino Preferred Language: _____________

Who referred you to our Practice? ____

Allergies:___________________________ **Medications:** ________________________________

Fish _______________ **Peanuts**______________ **Latex** ________________**Other**________________

Pharmacy Name: ________________________________ **Location:** ______________________________

Medication:	**Dosage**
1)______________________________________	______________________________
2)______________________________________	______________________________
3)______________________________________	______________________________
4)______________________________________	______________________________
5)______________________________________	______________________________
6)______________________________________	______________________________
7)______________________________________	______________________________
8)______________________________________	______________________________
9)______________________________________	______________________________